Mississippi Autism Board

P.O. Box 136
Jackson, MS 39205
Telephone (601) 359-6792 Fax (601) 576-2570 www.MSAutism.sos.ms.gov

Request for Investigation

The Mississippi Autism Board (MAB) only has authority to investigate its licensees or unlicensed persons holding themselves out as and/or providing services as Behavior Analysts or Assistant Behavior Analysts as certified by the Behavior Analyst Certification Board®, Inc. (BACB®).

Instructions: Please complete this form in its entirety. To the extent possible, give full details of the investigation request. Information provided will only be used for the purpose of the investigation. This form must be notarized prior to submission to MAB.

Requestor Information

Name _____ Phone _____

Address _____ Work Phone _____

City _____ State _____ ZIP _____

Behavior Analyst or Assistant Behavior Analyst to be Investigated

Name _____ Work Phone _____

Organization (Group, Hospital, Clinic, etc) _____

_____

Address _____ Email _____

City _____ State _____ ZIP _____

Unlicensed Person Claiming to Provide Services as a Behavior Analyst or Assistant Behavior Analyst

Name _____ Work Phone _____

Organization (Group, Hospital, Clinic, etc) _____

_____

Address _____ Email _____

City _____ State _____ ZIP _____

Complaint Details and Information for Investigation by MAB

Please summarize the details and information of your complaint as clearly and concisely as possible. Additionally, please describe in other information or documentation you possess or have knowledge of that is pertinent to your complaint. You may use attach additional documents or information if necessary.

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Please provide any additional documentation you deem necessary and pertinent that will support the above allegations. If court documents, including, but not limited to, transcripts, reports, deposition(s), etc. are the basis of the complaint, you must provide them to the MAB before an investigation can proceed.

I understand that by filing this request for investigation, I am giving the Mississippi Autism Board permission to inquire into information that is normally held confidential between myself and the licensee, I have filled out the release of information form on page 3, and

Hereby authorize the Mississippi Autism Board to investigate and resolve this matter in accordance with its Rules and Regulations, and

I certify that all the information I have given herein is true, correct and compete to the best of my knowledge.

Signature of Complainant _____ Date _____

<u>* Notarization is Required:</u>

STATE OF: _____

COUNTY OF: _____

DATE: _____

SWORN BEFORE ME THIS DAY _____**OF** _____**A.D. 20** _____

SIGNATURE OF NOTARY PUBLIC_____

PRINTED OR TYPED NAME: _____

MY COMMISSION EXPIRES: _____

SEAL

Authorization for Release of Information

Name _____ Phone _____

Address _____

City _____ State _____ ZIP _____

I, the undersigned, hereby authorize the following to disclose ALL psychological, psychiatric, medical, substance-abuse, and legal information or records concerning:

_____

_____

_____

To: Mississippi Autism Board

P.O. Box 136

Jackson, MS 39205

Attn: Request for Investigation

Records of (specify individual, clinic, hospital, organization, etc. and provide address):

_____

_____

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_____

And release the above individual/institution from legal responsibility or liability for the release of my records or information. The disclosure of records authorized herein is required for official use, including investigation of possible proceedings regarding any violations of the laws of the State of Mississippi.

This authorization shall remain valid until the Mississippi Autism Board completes its investigation and proceedings arising out of the investigation.

I understand that I have a right to receive a copy of this authorization by me. A copy of the authorization shall be as valid as the original.

Signature of Complainant _____ Date _____

Representative Signature _____Relationship _____ Date _____

Witness Signature _____ Date _____